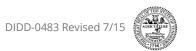
NOTICE OF DEATH FORM

Phone #

East DIDD Regional Director

(865) 588-0508



West DIDD Regional Director

(901) 745-7361

Phone #

Within 4 hours of the discovery of a death that is or may be a Suspicious, Unexpected, or Unexplained Death, the entity responsible for reporting the death shall report it to the DIDD Investigator. Also, **within 4 hours** of the discovery of any death, the primary provider must notify the DIDD Regional Office Administrator of the Day or, if applicable, the DIDD ICF/ID Director or Chief Officer or designee by telephone. A completed **Notice of Death Form** must be sent **within 1 business day** after discovery of the death. If a waiver provider or private ICF/IID, send it to the DIDD Regional Director. If a developmental center, send it to the DIDD Facilities Administrator and to the Deputy Commissioner.

(615) 231-5436

Middle DIDD Regional Director

Phone #

(865) 558-0226 Fax # (615) 231-5350 Fax # (901) 745-7251 Fax # Crisis Pager (855) 828-4717 Crisis Pager (615) 218-0784 Crisis Pager (866) 925-4204 PERSON SUPPORTED INFORMATION **DIDD REGION**: [] East [] Middle [] West DATE OF BIRTH: NAME: __ SOCIAL SECURITY NO: AGE AT DEATH: **RACE**: [] White [] Black [] Hispanic [] Other **SEX**: [] Male [] Female **CLASS MEMBER STATUS**: [] Settlement Agreement [] Not applicable **FUNDING STATUS** [] "Statewide" Waiver [] "Self-Determination" Waiver [] Private ICF/ID [] CAC Waiver [] State-Funded [] Developmental Center [] State ICF/ID **RESIDENCE** [] Lived with family [] Supportive Living [] Private ICF/ID [] Lived in Own Home with Support [] Residential Habilitation [] Developmental Center [] Medical Residential Services [] Lived Independently [] Nursing Facility [] Other (explain) _____ [] Family Model Residential Services DID THE PERSON SERVED MOVE IN THE PAST 6 MONTHS? [] No [] Yes (specify date: _____ DATE OF DEATH: __ DATE REPORTED: TIME REPORTED: _____ AM / PM PLACE OF DEATH [] Psychiatric Facility [] Home [] Hospital [] Other (explain) DETAILS OF DEATH 1. AUTOPSY REQUESTED? 2. MEDICAL EXAMINER CONTACTED? [] No [] Yes, If so, by whom _____ 3. CORONER CONTACTED? 4. INCIDENT FORM SUBMITTED? [] No [] Yes **INDICATE WHO HAS BEEN NOTIFIED** [] Legal Representative [] Family [] DIDD Investigator [] ISC/Case Manager [] Police NAME OF PRIMARY CARE PROVIDER: PHONE NO: TYPE OF CASE MANAGER [] ISC [] State Case Manager [] QMRP PHONE NO: _____ NAME OF CASE MANAGER: _____ NAME OF ISC AGENCY: PHONE NO:



NEXT OF KIN and/or **LEGAL REPRESENTATIVE**: _____

NOTICE OF DEATH FORM



| GENERAL HEALT | HCARE INFORMATION | | | | |
|---|--|-------------------|--|-------------|--|
| NAME OF PERSO | N SUPPORTED: | | | | |
| AMBULATION: | [] Ambulatory [] Non-Ambulatory | COMMUNICATION: | [] Verbal [] Non-verbal | | |
| NUTRITION: | [] Eats Independently [] Eats w/ Assistance [] Tube fed | WEIGHT IS: | [] Normal Weight [] Overweight [] Underweight | WEIGHT: | |
| PHYSICAL STATUS REVIEW (if applicable) | | DATE OF LAST PSR: | | PSR LEVEL: | |
| MEDICATIONS: | | | | | |
| Etiology (if know | DISABILITY [] Mild n): SYCHIATRIC DIAGNOSES: | | [] Profound [] Un | · | |
| GENERAL MEDIA | CAL DIAGNOSES: | | | | |
| HOSPITALIZATIO | DNS / PROCEDURES (over the | e past 12 months) | | | |
| Reason for Hospitalization / Procedure: Treatme | | | ocation: | Date: | |
| Name of Provider, Private ICF/IID, or DIDD Developmental Center | | | | none Number | |
| Person Completing this Form (please print) | | | | tle | |
| Signature | | | Da | Date | |